(2) a capital cost component calculated in accordance with section 86-1.59 of this Subpart.

(3) In addition, hospitals may be paid:

(i) long length of stay outlier payments, equal to the per diem rate established pursuant to section 86-1.55(b) of this Subpart, for every day of acute care in excess of the long length of stay outlier trimpoint as set forth in section 86-1.63 of this Subpart;

(ii) high cost outlier payments calculated pursuant to the provisions of section 86-1.55(c) of this Subpart;

(iii) short length of stay outlier payments calculated according to the provisions of subdivision (a) of section 86-1.55 of this Subpart in lieu of the payments specified in this section if the case meets the criteria for a short length of stay as defined in section 86-1.50 (g) (2) of this Subpart; and

(iv) transfer payments calculated according to the provisions of section 86-1.54(l) of this Subpart in lieu of all

other payments specified elsewhere in this section if the patient is a transfer patient as defined in section 86-1.50(j) of this Subpart.

(4) A [~~primary~~] health care services allowance of [~~.23 percent~~] .614 percent for rate year 1994 and .637 percent for rate year 1995 of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58 shall be added to all DRG case-based rates of payment calculated pursuant to paragraph (1) of this subdivision, and to rates or supplemental payments made pursuant to paragraph (3) of this subdivision.

(b) Exempt hospitals and units. Payments to hospitals for acute care services that are exempt from DRG case-based payment rates shall be established pursuant to section 86-1.57 of this Subpart. The hospital specific costs identified in subparagraph (a)(1)(ii) of this section shall be apportioned to the exempt unit operating per diem based on the data provided by the hospital. These payments shall include a [~~primary~~] health care services allowance of [~~.23 percent~~] .614 percent for rate year 1994 and .637 percent for rate year 1995 of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(c) Alternative level of care payments. Hospitals providing alternative level of care services as defined in section 86-1.50 of this Subpart shall be reimbursed for this care pursuant to the provisions of section 86-1.56 of this Subpart. These payments shall include a [~~primary~~] health care services allowance of [~~.23 percent~~] .614 percent for rate year 1994 and .637 percent for rate year 1995 of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(d) Secondary Payor payments.

(1) Co-insurance and deductibles. (i) Effective for all patients discharges after January 1, 1988 but before August 1, 1988 and notwithstanding the provisions of paragraph (2) of this subdivision, the sum of the payments made to a provider by a primary payor and a secondary payor(s) assuming liability for

coinsurance and deductibles for an acute care stay shall equal the case based payment per discharge amount determined on behalf of the primary payor pursuant to the provisions of section 86-1.51. For purposes of determining the secondary payor's or payors' coinsurance payment(s), the coinsurance percentage(s) shall be

applied to the primary payor's case based payment per discharge amount determined pursuant to the provisions of section 86-1.51 of this Subpart after consideration of any deductible.

(2) Exhaustion of benefits. Exhaustion of benefits shall not mean assumption of liability for coinsurance and/or deductibles. The payments made to a provider by a primary payor and a secondary payor(s) assuming liability in the event of exhaustion of benefits from the primary payor shall be determined as follows:

(i) Payment by a primary payor. The payment made to the provider by the primary payor shall be determined by apportioning the case based payment per discharge amount determined on behalf of the primary payor pursuant to the provisions of section 86-1.51 of this subpart on the basis of charges that accrue to the primary payor, relative to total charges for the acute care stay adjusted for uncovered services such that the accrued charges are consistent with the coverage of the primary payor's insurance policy and, any deductible(s) applied. For purposes of this subparagraph, a primary payor shall include benefits available pursuant to title XVIII of the Federal Social Security Act (Medicare).

(ii) Payment by secondary payor(s). The payment(s) made to the provider by the secondary payor(s) defined in section 86-1.51(a) or (c) of this Subpart shall be determined by apportioning the case based payment per discharge amount that would be paid by such secondary payor(s) pursuant to the provisions of section 86-1.51(d), had the secondary payor(s) been primary payor. This amount shall be apportioned on the basis of charges that accrue to the secondary payor(s), relative to total charges for the acute care stay adjusted for uncovered services, such that the accrued charges are consistent with the coverage of the secondary payor's or payors' insurance policy or policies and, any deductibles(s) applied. The accrued charges shall include charges for any services not covered by the primary payor but covered by the secondary payor's policy.

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(3) For purposes of determining total payment to the provider pursuant to the provisions of this subdivision, in no event shall the sum total of the accrued charges used in determining payments exceed total charges for the acute care stay to the hospital.

(4) For purposes of this subdivision the following definitions shall apply:

(i) An acute care stay shall mean that portion of the inpatient stay excluding ALC days defined in section 86-1.50(h).

(ii) The case based payment per discharge amount shall include inlier and outlier payments.

(iii) Charges shall be those charges accrued by date of service.

(e) Notwithstanding any inconsistent provision of this Subpart, general hospital contract costs incurred in accordance with section [~~405.42(b)(3)~~] 405.9(g)(2)(iii) of this Title may be included as an additional charge for general hospital inpatient services in determining patient charges for payors defined pursuant to section 86-1.51(d) of this Subpart or as a charge in addition to rates of payment for hospital inpatient services in determining payment due for payors included in the payor categories specified in section 86-1.51(a) of this Subpart if a payor has not designated a review agent for such payor's subscribers or beneficiaries or enrolled members, and for the payors specified in section 86-1.51(c), (e) and (f) of this Subpart.

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Supersedes TN 88-36 Effective Date JAN 0 1 1994

Section 86-1.53 Blended Rates of Payment. (a) For rates of payment for admissions in 1988, the DRG specific operating cost component shall be the sum of 90 percent of the hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined pursuant to of section 86-1.54(a) of this Subpart and 10 percent of the hospital's group average reimbursable inpatient operating cost per discharge determined pursuant to of section 86-1.54(b) of this Subpart multiplied by the service intensity weight for each DRG set forth in section 86-1.62 of this Subpart.

(b) For rates of payment for discharges in 1989, the DRG specific operating cost component shall be the sum of 75 percent of the hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined pursuant to section 86-1.54(a) of this Subpart and 25 percent of the hospital's group average reimbursable inpatient operating cost per discharge determined pursuant to section 86-1.54(b) of this Subpart multiplied by the service intensity weight for each DRG set forth in section 86-1.62 of this Subpart.

(c) For rates of payment for discharges in 1990 and thereafter, the DRG specific operating cost component shall be the sum of 45 percent of the hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined pursuant to section 86-1.54(a) of this Subpart and 55 percent of the hospital's group average reimbursable inpatient operating cost per discharge determined pursuant to section 86-1.54(b) of this Subpart multiplied by the service intensity weight for each DRG set forth in section 86-1.62 of this Subpart, except as provided in subdivision (d) of this section.

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(d) for rates of payment for discharges in 1991 and thereafter, a general hospital having less than 201 certified acute non-exempt inpatient beds that is classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of Title XVIII of the federal Social Security Act (Medicare) since the hospital is located in a rural area as defined by federal law (see 42 U.S.C. section 1395 ww(d)(2)(D) or defined as a rural hospital under state law may choose to have its DRG specific operating cost component be 100 percent of the hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined pursuant to section 86-1.54(a) of this Subpart multiplied by the service intensity weight for each DRG set forth in section 86-1.62 of this Subpart. In order to exercise this option for 1991 or subsequent rate years, the general hospital shall notify the Department of such election in writing by no later than December first of the preceding rate year or a later date as determined by the Commissioner.

TN 91-6 Approval Date AUG 4 1993

Supersedes TN New Effective Date JAN - 1 1991

86-1.54 Development of DRG case-based rates of payment per discharge. (a) The hospital-specific average reimbursable inpatient operating cost per discharge shall be determined by dividing hospital-specific non-Medicare reimbursable operating costs determined pursuant to paragraph (1) of this subdivision by non-Medicare discharges determined pursuant to paragraph (2) of this subdivision and dividing this result by the hospital-specific case mix index determined pursuant to paragraph (3) of this subdivision.

(1) Hospital-specific non-Medicare reimbursable operating costs shall be the hospital's 1987 reimbursable operating costs trended to the rate year pursuant to section 86-1.58 of this Subpart including any adjustments made pursuant to section 86-1.52(a)(1)(iii)(a)[~~and~~](iv), and (v) of this Subpart but excluding the following costs:

(i) Medicare costs as defined in subdivision (c) of this section including any costs of a Medicare patient's stay paid for by or on behalf of a secondary payor;

(ii) ALC costs as defined in subdivision (d) of this section;

(iii) exempt unit costs as defined in subdivision (e) of this section;

(iv) transfer costs as defined in subdivision (f) of this section;

(v) short-stay outlier costs as defined in subdivision (f) of this section; and

(vi) high-cost outlier costs as defined in subdivision (f) of this section.

(2) Non-Medicare discharges. Non-Medicare discharges for each hospital shall be all 1987 discharges not related to beneficiaries of title XVIII of the federal Social Security Act excluding exempt